STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155458	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND NURSING AND REHABILITATION CENTER	9630 FIFTH ST HIGHLAND, IN46322

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: May 16, 17, 18, 19 and 20, 2011 Facility number: 000367 Provider number: 155458 AIM number: 100289280 Survey team: Kathleen (Kitty) Vargas, RN, TC Lara Richards, RN Heather Tuttle, RN Janet Adams, RN Census bed type: SNF/NF: 29 Total: 29 Census payor type: Medicare: 6 Medicaid: 18 Other: 5 Total: 29 Stage II Sample: 25 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on May 26, 2011 by	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Bev Faulkner, RN			

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F0156 SS=E	The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;			

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	A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.			

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	The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to ensure 4 of 4 residents whose resident trust accounts were reviewed, received written notification of a list of chargeable items upon admission. The facility also failed to ensure 1 of 3 residents reviewed for notification of the discontinuation of skilled services, received timely notification prior to the end of services. (Residents #7, #21, #26, #28 and #35) Findings include: 1. Interview with Resident #26's family member on 5/16/11, indicated they had not received notification of what items the resident was to be charged for. Review of the resident's trust account on 5/19/11 at 2:00 p.m., indicated the Administrator was not aware if the resident's family had received a list of what items were not covered under the resident's daily	F0156	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 156 Resident Inform of Rights/Rules of facility a. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Issue # 1 - Resident # 26, 21, 28, and 35 were provided with written notification of a list of chargeable items, including what was covered by Medicaid and/or Medicare. Issue # 2 – Resident # 7's responsible party was given notice of non-coverage and has not chosen to appeal the coverage determination. The SSD and NHA were given a teachable moment regarding the facility's "Notice of Medicare Provider Non-Coverage "standard and guideline. **b. How you will identify other residents having**	06/19/2011

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	rate. Interview with the Administrator on 5/20/11 at 8:08 a.m., indicated the resident's family did not receive a schedule of charges from the facility. 2. Review of the resident funds accounts on 5/19/11 at 2:00 p.m., indicated Resident #21 was admitted to the facility on 2/28/11, Resident #28 was admitted to the facility on 11/26/10 and Resident #35 was admitted to the facility on 2/15/11. There was no documentation to indicate if the above residents received a schedule of charges indicating what was covered by Medicare and/or Medicaid services. Interview with the Administrator on 5/20/11 at 8:08 a.m., indicated the residents did not receive a schedule of charges from the facility at the time of admission.		**potential to be affected by the same practice and what corrective action will be taken:** Issue # 1 –An audit of current residents was completed to ensure were provided with written notification of a list of chargeable items, including what was covered by Medicaid and/or Medicare. Issue # 2 – All residents currently residing in the facility that have been discharged from Medicare Part A services in the last 30-day were reviewed to ensure appropriate receipt and completion of the SNFABN could be evidence in the resident's medical record. Anyone identified as not having appropriately received the SNFABN the appropriate option boxes will have their rights explained and receive a new SNFABN form. **c. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** The facility's administrative staff were re-educated by the Regional A/R Analyst on the components of this regulation with emphasis on:S & G on Business Office ReviewS & G Admission Folder List Standard and Guideline regarding: Notice for Discontinuation of Skilled Services (SNFABN Notice (CMS-10055, Medicare Provider Non-Coverage (CMS -1023) and Detailed Explanation Coverage (CMS -10124) in detail with the	

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			appropriate department heads who have the responsibility to explain and complete these forms and/or issue to the resident's that qualify of receipt of said forms. The Medicare Claims Processing manual, Chapter 30 as it pertains to issuance of the SNFABN and completion of the overall form. The BOM/designee will bring daily audit of admission packets to AM meeting and notify NHA of any outstanding packets The SSD will review the Notice for Discontinuation of Skilled Services at the weekly UR meeting for appropriateness of dates. **d. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** The NHA or designee will review each new admission to ensure they were issued a notification of a list of chargeable items, including what was covered by Medicaid and/or Medicare. These audits will be completed for the next four weeks then monthly times 2 months to determine if substantial compliance is achieved. The MDSC or designee will monitor weekly for the next 4 weeks (then 2 times monthly for 2 months) for the SNFABN process as it pertains to issuance of the SNFABN and completion of the overall form.Report of these findings will be presented at the monthly Risk Management/QA	

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	3. On 5/18/11, the facility provided a list of residents whose skilled services were discontinued. Resident #7 was listed as having her skilled services discontinued on 3/1/11. The Administrator provided a copy of the "Notice of Medicare Provider Non-Coverage" form for Resident #7. The form was completed by the Social Service Director. He indicated the resident was notified on 2/28/11 at 9:00 a.m. that her last day of skilled services would be 3/1/11. He also indicated the resident's granddaughter was notified on 2/28/11 at 10:00 a.m. that the resident's last day of skilled services would be 3/1/11. The policy titled, "Notice for Discontinuation of Skilled Services" and dated 11/12/07, was provided by the Administrator on 5/18/11 at 5:05 p.m. He indicated the policy was current. The policy indicated: The facility will give a completed copy of the Medicare Provider Non-Coverage (Form No.		meeting to determine if compliance has been met, and Quarterly oversight will be completed by the Regional Field Analyst.e. **Date of compliance:** 6/19/11	

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	CMS-10123) to the resident no later than 2 days before termination of skilled services. When interviewed on 5/18/11 at 4:55 p.m., the Administrator indicated the "Notice of Medicare Provider Non-Coverage" form was not given to the resident and the responsible party in a timely manner. He indicated it should have been given 2 days prior to the end of skilled services. 3.1-4(a) 3.1-4(f)(1)(A)			

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F0159 SS=A	Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act;			

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	and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. Based on record review and interview, the facility failed to ensure quarterly statements were provided to 1 of 4 residents whose resident funds were reviewed. (Resident #36) Findings include: 1. Interview with Resident #36 on 5/16/11 at 1:20 p.m., indicated that she was not aware of how much money she had in her personal funds account. Review of the resident funds accounts on 5/19/11 at 2:00 p.m., indicated no quarterly statements were available for review. Interview with the Administrator on 5/20/11 at 8:30 a.m., indicated the facility does send out quarterly statements, however, the Business Office Manager was on vacation and he could not locate the quarterly statements. **3.1-6(g)**	F0159	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F-159 Facility Management of Personal Funds (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Residents who have personal fund accounts with this facility (that are alert) along with responsible parties (i.e., POAs, Guardians, etc.), were given a statement of their personal funds with include their interest allocation. BOM has received a teachable moment regarding the requirement of the quarterly fund/interest statements. **(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:** Review was completed to identify residents who have personal fund accounts with this facility so that a current quarterly statement could be provided to all – including	06/19/2011

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			responsible parties/POA/guardians. **(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** Business Office Manager have been re-educated on the components of this regulation with emphasis on the requirement of quarterly interest statements Review of the Standard and Guidelines for Management of Resident Funds was review with current BOM and Administrator. **(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** The Corporate A/R Analyst or designee will review the Resident trust to ensure the residents' interest is allocated by the 15th of each month and that statements are generated and issued quarterly to each participating resident and/or responsible party. The Business Office Manager or designee will review each newly admitted resident's record for written authorization for the facility to manage their account. The Facility Risk Manager will report results at the next QA/Risk Management meeting and monthly thereafter until substantial compliance has been achieved and it has been recommended quarterly	

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			monitoring to maintain compliance **(e) Date of Compliance:** 6/19/2011	
F0223 SS=D	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure residents remained free of verbal abuse, related to inappropriate statements made by a staff member to a resident for 1 of 4 allegations of abuse reviewed. (Resident #19) (RN #1) Findings include: The investigation of an allegation of abuse for Resident #19 was reviewed on 5/19/11 at 10:32 a.m. The incident occurred on 3/30/11. The investigation indicated an employee heard RN #1 state to the resident "you s- - - pants all the time so go ahead no one is stopping you." The facility's immediate actions included suspension of the RN and Physician and family notification of the allegation. No physical or emotional injuries/ distress noted. The facility investigation included interviews obtained from other residents. The resident interviews were obtained on 4/4/11. The Social Worker obtained interviews from four other residents. One of the interviews indicated another resident stated another staff member was mean to her. There was no follow up related to the above statement obtained during the investigation. The record for Resident #19 was reviewed on	F0223	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F-223 Abuse (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Resident #19's allegations were reported to IDOH as required on 03/30/11. RN #1 no longer works at the facility Resident #32 allegations of rough treatment were reported to IDOH on 5/19/11 The Social Service Director was reeducated on the facility standard and guidelines for reporting abuse neglect and exploitation. . **(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:**	06/19/2011

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	5/19/11 at 1:13 p.m. The resident's diagnoses included, but were not limited to, severe dementia, osteoarthritis, and severe dysphagia (a swallowing disorder). The 5/4/11 Minimum Data Set (MDS) quarterly assessment indicated the resident had short and long term memory problems and had difficulty with making decisions in new situations. The assessment also indicated the resident required total assistance with personal hygiene. When interviewed on 5/19/11 at 12:20 p.m., the Director of Nursing indicated the RN was suspended at the time and the RN came in the next morning and resigned. The Director of Nursing indicated she was not aware of the allegations made by the other resident that were interviewed during the investigation. When interviewed on 5/19/11 at 12:28 p.m., the Social Worker indicated he had obtained the resident interviews on 4/4/11 and informed the Administrator (previous) who was here at the time. The Social Worker indicated he did not feel the residents statements were considered abuse. 3.1-27(b)		Residents who are cognitively intact were interviewed to determine if any allegations of abuse/neglect had not been reported to facility staff and reported according to the facility standard and guidelines and none were reported **(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** The Social Service Director or Designee will meet bi-weekly with the Resident Council to ensure any allegations of abuse, neglect, and or exploitation are brought to the Administrator and Risk Manager for investigating, reporting, resolution, and follow-up in a timely manner until the Council determines bi-weekly meetings with SSD are no longer necessary. The Facility Management Team will review all event reports, grievances, and concerns daily during their routine stand up meeting in order to investigate, resolve, and follow-up with any allegations of abuse neglect or exploitation in a timely manner. **(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** The Administrator or designee will randomly interview 5 residents weekly x 4 weeks, then monthly for 2 additional months to determine if any	

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			allegations of abuse neglect or exploitations have been made and reported promptly. The facility Risk manager will report of these findings at the next monthly QA/Risk Management meeting until such time substantial compliance as been met and quarterly oversight by the RDCO is recommended when completing her system review which has a focus on A-N-E. **(e) Date of compliance:** 6/19/11	
F0224 SS=A	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure each resident was free from neglect related to two CNA's not providing incontinence care for 1 of 4 residents reviewed for abuse. (Resident #13) (CNA's #4 & #5) Findings include: The investigation of an allegation of neglect for Resident #13 was reviewed on 5/19/11 at 10:32 a.m. The investigation indicated the resident reported to the on-coming CNA on the 2:00 p.m. to 10:00 p.m. shift that CNA's failed to perform incontinence care for her. The allegation occurred on 4/21/11 at 2:30	F0224	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F-224 Staff Treatment of Residents (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Resident #13's allegations were reported to IDOH as required on 4/21/11 and Employee #4 and #5 have since been terminated – following their suspension and investigation. **(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be**	06/19/2011

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	p.m. Immediate actions taken by the facility included providing incontinence care to the resident and suspension of the two involved CNA's. Staff inservicing was also done related to the abuse policy. The facility obtained a statement from Resident #13 on 4/22/11. The resident's statement indicated she was in bed and needed to go the restroom and two girls came in and told her to go in her brief and they would just clean it up. The resident also indicated in the statement that this had happened before and it was the same two girls. The facility obtained statements from staff members. One of the statements indicated the resident reported that a staff member told her to go in her pants. Another statement indicated the resident reported that two girls refused to take her to the bathroom and they told her to go "pee" in bed. When interviewed on 5/19/11 at 12:20 p.m., the Director of Nursing indicated she was informed of the above incident and initiated an investigation. The two CNA's were suspended at the time and did not return to work. The allegation of neglect of care was substantiated based on the resident's		**taken:** Residents who are cognitively intact were interviewed to determine if any allegations of abuse/neglect had not been reported to facility staff and reported according to the facility standard and guidelines and none were reported. **(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** Staff were reeducated on abuse neglect and exploitation per facility standard and guidelines on 05/19/11 and 05/20/11. The Social Service Director or Designee will meet bi-weekly with the Resident Council to ensure any allegations of abuse, neglect, and or exploitation are brought to the Administrator and Risk Manager for investigating, reporting, resolution, and follow-up in a timely manner until the Council determines bi-weekly meetings with SSD are no longer necessary. The Facility Management Team will review all event reports, grievances, and concerns daily during their routine morning stand up meeting in order to investigate, resolve, and follow-up with any allegations of abuse neglect or exploitation in a timely manner. **(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be**	

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	consistency in reporting the incident and the interviews of co-workers. The Director of Nursing indicated CNA #4 and CNA #5 were terminated. 3.1-28(a)		**put into place:** The Administrator or designee will randomly interview 5 residents weekly x 4 weeks, then monthly for 2 additional months to determine if any allegations of abuse neglect or exploitations have been made and reported promptly. The facility Risk manager will report of these findings at the next monthly QA/Risk Management meeting until such time substantial compliance as been met and quarterly oversight by the RDCO is recommended when completing her system review which has a focus on A-N-E. (e) **Date of compliance:** 6/19/11	

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to ensure allegations of abuse were investigated thoroughly related to investigating an allegation of physical abuse for 2 of 4 abuse allegations	F0225	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies.	06/19/2011

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	reviewed and failing to address an interview obtained by a resident during an investigation of abuse for 1 of 4 abuse investigation. (Residents #42, #19, and #32) (RN #1 and LPN #1). The facility also failed to ensure criminal history checks were obtained as required for 1 of 5 employees reviewed for criminal background checks. (Dietary Employee #1) Finding include: 1. The investigation of an allegation of abuse was reviewed on 5/19/11 at 10:32 a.m. An allegation of abuse was made by Resident #42 on 12/7/10. The investigation indicated the resident reported to a nursing assistant that she was touched on her breast. The investigation report indicated that no physical or emotional injuries or distress was noted to the resident. The investigation report indicated that an investigation was initiated and the results of the investigation did not support the allegation as the resident reported a Mexican resident wheeled himself over to her at the Christmas party. Both of the Hispanic residents in the facility required total assist. The report also indicated the facility had not had a Christmas party yet. The family of the resident was contacted and they said the resident will repeat		This plan of correction is prepared and/or executed solely because required. F-225 Staff Treatment of Residents (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:Resident #42 no longer resides in the facility. Resident #19's allegations were reported to IDOH as required on 03/30/11 and RN #1 no longer works at the facility Resident #32 allegations of rough treatment were reported to IDOH on 5/19/11 Dietary Employee #1 had a background check completed for Indiana on 5/26/11 and the results were placed in the employee file. The Social Service Director was reeducated on facility standard and guidelines for reporting abuse neglect and exploitation on 5/19/11. The Administrator was reeducated on the requirements for obtaining background checks on employees according to Indiana and facility standards on 5/19/11. .**(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:** Residents who are cognitively intact were interviewed to determine if any allegations of abuse had not been reported according to facility, state, and federal requirements. Current employee files were audited to ensure background checks had been completed appropriately	

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	things that are funny and they were not concerned with the resident's statements. Preventative measures taken by the facility were listed as staff inserviced routinely on abuse and the Administrator and Director of Nursing will follow up and continue to monitor and report findings to the QA (Quality Assurance) committee. The report indicated the investigation was completed. The closed record for Resident #42 was reviewed on 5/19/11 at 10:50 a.m. The resident was admitted to the facility on 11/3/10. The resident's diagnoses included, but were not limited to, convulsions, high blood pressure, debility, aftercare following surgery of the nervous system. A 10/27/10 hospital consultation note indicated the resident had a history of an AV (arterial/venous) malformation and aneurysm with brain surgery. The 12/10 Nurses' Notes were reviewed. An entry made on 12/7/10 at 12:00 p.m., indicated the resident reported that a man touched her breast a couple of days ago. The writer and the Administrator interviewed the resident who concurred a Hispanic man touched her breast and seems to think it happened at the Christmas Party. Social Service Progress Notes were		and filed in the employee record. **(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** Staff were reeducated on abuse neglect and exploitation per facility standard and guidelines on 05/19/11 and 05/20/11. The Social Service Director or Designee will meet bi-weekly with the Resident Council to ensure any allegations of abuse, neglect, and or exploitation are brought to the Administrator and Risk Manager for investigating, reporting, resolution, and follow-up in a timely manner until the Council determines bi-weekly meetings with SSD are no longer necessary. The Administrator or designee will review new employee records to ensure background checks have been completed and filed according to Indiana and facility standards The Facility Management Team will review event reports, grievances, and concerns daily during their routine morning stand up meeting in order to investigate, resolve, and follow-up with any allegations of abuse neglect or exploitation in a timely manner **(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** The Administrator or designee will	

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	reviewed. An entry made on 12/8/10 indicated the resident informed staff that she thinks a peer might have touched her breast inappropriately and the resident cannot recall the exact date. The entry also noted there were only two Hispanic residents in the facility and both of the residents were bed bound. The note also indicated there were no visitors that fit the description. The facility was unable to provide any further documentation of the actions taken during the investigation. When interviewed on 5/19/11 at 12:28 p.m., the Social Worker indicated he had interviewed staff members related to this allegation and turned them in. The Social Worker indicated interviews were also done with other residents and given to the Administrator (previous Administrator) at the time. When interviewed on 5/20/11 at 11:44 a.m., the Social Worker indicated he had no documentation of the above interviews. 2. The investigation of an allegation of abuse for Resident #19 was reviewed on 5/19/11 at 10:32 a.m. The incident occurred on 3/30/11. The investigation		randomly interview 5 residents weekly x 4 weeks, then monthly for 2 additional months to determine if any allegations of abuse neglect or exploitations have been made and reported promptly.The Administrator or designee will randomly review 5 employee files weekly x 4 weeks, then monthly for 2 additional months to determine facility compliance with background checks on employees.The facility Risk manager will report of these findings at the next monthly QA/Risk Management meeting until such time substantial compliance as been met and quarterly oversight by the RDCO is recommended when completing her system review which has a focus on A-N-E. **(e) Date of compliance:** 6/19/11	

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	indicated an employee heard RN #1 state to the resident "you s- - - pants all the time so go ahead no one is stopping you." The facility immediate actions included suspension of the RN and Physician and family notification of the incident. No physical or emotional injuries/ distress noted. The facility investigation included interviews obtained from other resident's. The resident interviews were not obtained until 4/4/11. The Social Worker obtained interviews from four other residents. One of the interviews indicated Resident #32 was asked if she had any experiences where staff had been mean to her. The resident stated LPN #1 can be mean some times. There was no follow up related to the above statement obtained during the investigation. The record for Resident #19 was reviewed on 5/19/11 at 1:13 p.m. The resident's diagnoses included, but were not limited to, severe dementia, osteoarthritis, and severe dysphagia (a swallowing disorder). The 5/4/11 Minimum Data Set (MDS) quarterly assessment indicated the resident had short and long term memory problems and has difficulty with making decisions in new situations. The assessment also indicated the resident required total assistance with personal			

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	hygiene. The record for Resident #32 was reviewed on 5/20/11 at 9:41 a.m. The resident's diagnoses included, but were not limited to, anemia, high blood pressure, and cerebral vascular accident (stroke). The 2/16/11 Minimum Data Set (MDS) quarterly assessment indicated the resident scored a (15) on a BIMS (brief interview for mental status), a score of 15 indicates the resident is not cognitively impaired. When interviewed on 5/19/11 at 12:20 p.m., the Director of Nursing indicated the RN was suspended at the time and the RN came in the next morning and resigned. The Director of Nursing indicated she was not aware of the allegations made by Resident #32 that LPN #1 was mean to her. The Director of Nursing indicated this was an allegation of abuse. When interviewed on 5/19/11 at 12:28 p.m., the Social Worker indicated he had obtained the resident interviews on 4/4/11 and informed the Administrator (previous) who was here at the time. The Social Worker indicated he did not feel Resident #32's statement was abuse because there was a history between the two and the resident becomes anxious.			

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	When interviewed on 5/19/11 at 2:00 p.m., the Director of Nursing indicated the allegation made by Resident #32 was reviewed with the facility Administrator and LPN #1 was suspended at this time. The Director of Nursing indicated an investigation of the allegation of abuse related to the above was now being conducted. 3. The facility employee records were reviewed on 5/20/11 at 9:00 a.m. Dietary Employee #1 was hired on 3/28/11. A criminal background check was obtained from a county in the state of Illinois. A criminal background check was not obtained from the state of Indiana. When interviewed on 5/20/11 at 10:50 a.m., the facility Administrator indicated the background check was obtained from Illinois and not Indiana. 3.1-28(d)			

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F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow their abuse policy related to investigating allegations of abuse for 2 of 4 allegations of abuse reviewed and completing criminal history background checks for 1 of 5 employees whose files were reviewed. (Residents #42, #32, and #19) (Dietary Employee #1) Findings include: The facility policy titled "Investigation Protocol for alleged violations of Federal or State Laws" was reviewed on 5/17/11 ay 1:10 p.m. The Director of Nursing provided the policy and indicated the policy was current. The policy was issued on 10/04 and last revised on 3/11. The policy indicated all alleged violations which involve mistreatment, neglect, and seclusion were to be reported to the Administrator/DNS/designee. The policy indicated the facility was to investigate each alleged violation thoroughly and report the results to the Administrator/DNS/designee. If the suspect is an employee they were	F0226	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F-226 Practice and Guidelines regarding Abuse (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Resident #42 has been discharged from the facility. Resident #19's allegations were reported to IDOH as required on 3/30/11 and RN #1 no longer works at the facility Resident #32 allegations of rough treatment were reported to IDOH on 5/19/11 Dietary Employee #1 had a background check completed for Indiana on 5/26/11 and the results were placed in the employee file. The Social Service Director was reeducated on facility standard and guidelines for reporting abuse neglect and exploitation on 5/19/11. **(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be**	06/19/2011

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	to be placed on immediate suspension pending the results of the investigation. Investigation steps were to include interview of employee, visitors, or residents who may have knowledge of the incident. Written documentation was to be kept of each interview taken. The policy also indicated Federal law requires the facility to have evidence of the investigations of alleged mistreatment, neglect, abuse, injuries of unknown sources, and misappropriation of property. The facility policy titled "Abuse, Neglect, and Exploitation" was received from the Director of Nursing on 5/19/11 at 10:00 a.m. The Director of Nursing indicated the policy was current. The policy was issued on 11/04. The policy indicated criminal background checks were to required for the screening of new employees. The policy indicated the facility was to conduct their own internal investigation: "See Investigation Protocol for Alleged Violation of Federal and/or State Laws." **1. The investigation of an allegation of abuse was reviewed on 5/19/11 at 10:32 a.m. An allegation of abuse was made by Resident #42 on 12/7/10. The investigation indicated the resident reported to a nursing assistant that she was touched on her**		**taken:** Residents who are cognitively intact were interviewed to determine if any allegations of abuse had not been reported according to facility, state, and federal requirements. Current employee files were audited to ensure background checks had been completed appropriately and filed in the employee record. **(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** Staff were reeducated on abuse neglect and exploitation per facility standard and guidelines on 05/19/11 and 05/20/11. The Administrator was reeducated on the requirements for obtaining background checks on employees according to Indiana and facility policy on 05/19/11. The Social Service Director or Designee will meet bi-weekly with the Resident Council to ensure any allegations of abuse, neglect, and or exploitation are brought to the Administrator and Risk Manager for investigating, reporting, resolution, and follow-up in a timely manner until the Council determines bi-weekly meetings with SSD are no longer necessary. The Administrator or designee will review new employee records to ensure background checks have been completed and filed according to Indiana and facility standards	

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	breast. The investigation report indicated that no physical or emotional injuries or distress was noted to the resident. The investigation report indicated that an investigation was initiated and the results of the investigation did not support the allegation, as the resident reported a Mexican resident wheeled himself over to her at the Christmas party. Both of the Hispanic residents in the facility required total assist. The report also indicated the facility had not had a Christmas party yet. The family of the resident was contacted and they said the resident will repeat things that are funny and they were not concerned with the residents statements. Preventative measures taken by the facility were listed as staff inserviced routinely on abuse and the Administrator and Director of Nursing will follow up and continue to monitor and report findings to the QA (Quality Assurance) committee. The report indicated the investigation was completed. **The closed record for resident #42 was reviewed on 5/19/11 at 10:50 a.m. The resident was admitted to the facility on 11/3/10. The resident's diagnoses included, but were not limited to, convulsions, high blood pressure, debility, aftercare following surgery of the nervous system. A 10/27/10 hospital consultation note indicated the resident had a history of an AV (arterial/venous) malformation and aneurysm with brain surgery.** **The 12/10 Nurses' Notes were reviewed. An entry made on 12/7/10 at 12:00 p.m., indicated the resident reported that a man touched her breast a couple of days ago. The writer and the Administrator interviewed the resident who concurred a Hispanic man**		The Facility Management Team will review event reports, grievances, and concerns daily during the Monday through Friday stand up meeting in order to investigate, resolve, and follow-up with any allegations of abuse neglect or exploitation in a timely manner **(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** The Administrator/designee will randomly interview 5 residents weekly x 4 weeks, then monthly for 2 additional months to determine if any allegations of abuse neglect or exploitations (A-N-E) have been made and that they have been reported promptly. The Administrator/designee will randomly review 5 employee files weekly x 4 weeks, then monthly for 2 additional months to determine facility compliance with background checks on employees. The facility Risk manager will report of these findings at the next monthly QA/Risk Management meeting until such time substantial compliance as been met and quarterly oversight by the RDCO is recommended when completing her system review which has a focus on A-N-E. **(e) Date of compliance:** 6/19/11	

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	touched her breast and seems to think it happened at the Christmas Party. **Social Service Progress Notes were reviewed. An entry made on 12/8/10 indicated the resident informed staff that she thinks a peer might have touched her breast inappropriately and the resident cannot recall the exact date. The entry also noted there were only two Hispanic residents in the facility and both of the residents were bed bound. The note also indicated there were no visitors that fit the description.** **The facility was unable to provide any further documentation of the actions taken during the investigation.** **When interviewed on 5/19/11 at 12:28 p.m., the Social Worker indicated he had interviewed staff members related to this allegation and turned them in. The Social Worker indicated interviews were also done with other residents and given to the Administrator (previous Administrator) at the time.** **When interviewed on 5/20/11 at 11:44 a.m., the Social Worker indicated he had no documentation of the above interviews.** 2. **The investigation of an allegation of abuse for Resident #19 was reviewed on 5/19/11 at 10:32 a.m. The incident occurred on 3/30/11. The investigation indicated an employee heard RN #1 state to the resident "you s- - - pants all the time so go ahead no one is stopping you." The facility's immediate actions included suspension of the RN and Physician and family notification of the incident. No physical or emotional**			

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	injuries/ distress noted. **The facility investigation included interviews obtained from other resident's. The resident interviews were not obtained until 4/4/11. The Social Worker obtained interviews from four other residents. One of the interviews indicated Resident #32 was asked if she had any experiences where staff had been mean to her. The resident stated LPN #1 can be mean some times. There was no follow up related to the above statement obtained during the investigation.** **The record for Resident #19 was reviewed on 5/19/11 at 1:13 p.m. The resident's diagnoses included, but were not limited to, severe dementia, osteoarthritis, and severe dysphagia (a swallowing disorder). The 5/4/11 Minimum Data Set (MDS) quarterly assessment indicated the resident had short and long term memory problems and has difficulty with making decisions in new situations. The assessment also indicated the resident required total assistance with personal hygiene.** **The record for Resident #32 was reviewed on 5/20/11 at 9:41 a.m. The resident's diagnoses included, but were not limited to, anemia, high blood pressure, and cerebral vascular accident (stroke). The 2/16/11 Minimum Data Set (MDS) quarterly assessment indicated the resident scored a (15) on a BIMS (brief interview for mental status), a score of 15 indicates the resident is not cognitively impaired.** **When interviewed on 5/19/11 at 12:20 p.m., the Director of Nursing indicated the RN was suspended at the time and the RN came in the next morning and resigned. The Director**			

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	of Nursing indicated she was not aware of the allegations made by Resident #32 that LPN #1 was mean to her. The Director of Nursing indicated this was an allegation of abuse. **When interviewed on 5/19/11 at 12:28 p.m., the Social Worker indicated he had obtained the resident interviews on 4/4/11 and informed the Administrator (previous) who was here at the time. The Social Worker indicated he did not feel Resident #32's statement was abuse because there was a history between the two and the resident becomes anxious.** **When interviewed on 5/19/11 at 2:00 p.m., the Director of Nursing indicated the allegation made by Resident #32 was reviewed with the facility Administrator and LPN #1 was suspended at this time. The Director of Nursing indicated an investigation of the allegation of abuse was now being conducted.** **3.** The facility employee records were reviewed on 5/20/11 at 9:00 a.m. Dietary Employee #1 was hired on 3/28/11. A criminal background check was obtained from a county in the state of Illinois. A criminal background check was not obtained from the state of Indiana. When interviewed on 5/20/11 at 10:50 a.m., the facility Administrator indicated the background check was obtained from Illinois and not Indiana. 3.1-28(a)			

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F0247 SS=D	A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure notice of room change was provided prior to the change for 2 of 3 residents who met the criteria for room transfers. (Residents #28 & #36) Findings include: The policy titled, "Room Change/Roommate Assignment" was reviewed on 5/18/11 at 5:06 p.m. The policy was received from the Administrator at this time. The Administrator indicated the policy was current. The policy indicated "It will be the standard of the facility to honor the resident's right to receive notice before the resident's room or roommate in the facility is changed." The policy also indicated if a resident is being moved at the facility's request, a staff member was to explain the reason for the move and provide the resident with the opportunity to view the new location, meet the new roommate, and ask questions about the move. Documentation was to be made in the resident's medical record. 1. When interviewed on 5/16/11 at 12:46 p.m., Resident #28 indicated she had a room change in the last nine months. The resident indicated she was sent to the hospital and when she returned she required isolation and was placed in another room for about two weeks, The resident indicated after the isolation was over she was moved to another room and was told of the room change on the day she was moved. She was not notified which roommate she was going to have. The record for Resident #28 was reviewed on 5/17/11 at 2:07 p.m. The resident's diagnoses	F0247	**Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.** **F 247 Notification of Roommate Change** **(A)What corrective actions will be accomplished for those residents found to have been affected by the practice?** Issue # 1 and # 2 were identified after the fact – because of this staff offered an apology and explanation to Resident's # 28 and # 38 as to why room changes where made (initial based on Isolation needs) and secondary based on (removal from Isolation needs).. **(b) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken?** Facility audit was conducted of active residents to identify any room changes over that last 30 days to ensure that the appropriate notification process was being	06/19/2011

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	included, but were not limited to, hemiplegia and muscle weakness. The resident was first admitted to the facility on 11/26/10. The resident was sent to the hospital on 3/28/11 and was readmitted to the facility on 4/5/11. The resident was readmitted to room 1-B. A physician's order was written on 4/18/11 to move the resident to room 12-B. An entry in the 4/2011 Nurses' Notes was made on 4/18/11 at 1:45 p.m. This entry indicated the resident was moved to room 12-B. There was no documentation of the resident being notified prior to the room change or of the resident being given the opportunity to meet her new roommate prior to the move. The last entry in the 4/11 Social Service Progress Notes was made on 4/4/11. This entry indicated the resident was readmitted back the facility. There were no entries related to the resident's 4/18/11 room change. When interviewed on 5/19/11 at 10:15 a.m., the facility Administrator indicated the resident should have been informed of the room change and should have been involved in the room change. 2. When interviewed on 5/16/11 at 1:19 p.m., Resident #36 indicated she had had a room or room mate change in the last nine months. The resident indicated she was moved to another room and was not given notice beforehand. The record for Resident #36 was reviewed on 5/18/11 at 2:30 p.m. The resident was transferred to room 1-B on 4/18/11 for isolation. The resident was transferred to room 7-C on 5/9/11. The 5/2011 Nurses' Notes were reviewed. There was no documentation in the 5/9/11		followed. Any issues identified were addressed and/or corrected. **(c) What measures will be put into place or what systemic changes will be made to ensure that the practice does not recur?** Nursing Staff\ Social Services were re-educated on the components of F 247 and the need to ensure that the resident and family receive notice before the resident receives a room change or a new roommate. Any potential room changes or roommate changes will be reviewed with Social Service, DNS and Administrator to ensure appropriate notification and documentation has occurred prior to change, this will also include documentation in the nurse's notes along with the required MD order. Review of form FGS 1602 Notification of Room or Roommate Change was reviewed with the Social Services Director for appropriate use to be used prior to an actual room and/or roommate change along with the required f/u documentation. **(d) How will the corrective actions be monitored to ensure the practice will not recur and what quality assurance program will be put into place?** Admin\DNS\SSD will review the 24 hour report at each morning stand-up meeting for the next 4 weeks, making note of any room changes and review of the clinical record for accurate	

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	Nurses' Notes related to the resident's room change. There was no documentation in the 5/7/11 or 5/8/11 Nurses' Notes related to the resident being notified prior to the room change. There were no Social Service Notes made during 5/2011. When interviewed on 5/19/11 at 10:15 a.m., the facility Administrator indicated the resident should have been informed of the room change and should have been involved in the room change. 3.1-3(v)(2)		notification\documentation of resident and family\ responsible party. Identification of any discrepancy will result in an immediate follow up call to family/responsible party as well as a resident interview to ensure contentment with current room and/or roommate. Upon completion of the above - Social Service will complete an audit weekly (for the following two months) on any room and/or roommate changes to ensure timely notification was given to parties involved based on facility form FGS 1602. Results of these findings will be presented at the monthly Risk Management \Quality Assurance meeting to determine if compliance has been met and quarterly oversight by the RDCO is recommended when she completes her system reviews which includes room changes. **(e) Date of Correction:** 6/19/11	
F0250 SS=E	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure 3 of 5 residents who were receiving	F0250	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is	06/19/2011

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	anti-anxiety medications in the sample of 25 were receiving behavior monitoring. The facility also failed to ensure medically related social services were provided to 1 resident in the sample of 25 related to the use of an anti-depressant. (Residents #8, #11, #27 and #35) Findings include: 1. The record for Resident #11 was reviewed on 5/17/11 at 12:35 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's dementia and Obsessive Compulsive Behaviors. An entry in the Physician progress notes, dated 1/10/11, indicated the resident had been digging in the anal area and touching all other parts including her conjunctiva (area of the eye) and had developed chronic recurrent conjunctivitis. Documentation in the Nurses' notes on 1/12/11 at 8 p.m., indicated "Seen smearing BM (bowel movement) on bedding and observed scratching eyes with fingernail." A Physician's order, dated 1/24/11, indicated the resident was to receive Ativan (an anti-anxiety medication)		prepared and/or executed solely because required. F-250 Social Services (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Residents # 11, 35, 27, and 8 were reassessed by psychological services and the interdisciplinary team/SSD to ensure each resident has been properly assessed, appropriate medications ordered and/or tapered/discontinued, care planned with interventions that meet the needs of the particular behavior and documentation by the nursing and social services department to reflect the current residents behaviors, plans of care, and follow-up. The Pharmacy consultant will review resident medications for appropriate diagnosis and dosage to provide the optimum results. The Social Service Director, Licensed Nurses and Interdisciplinary Care Plan team were re-educated on the facility standards regarding assessment and management of behavior issues and the need for appropriate documentation and follow-up until resolved. **(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:**	

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	0.5 milligrams (mg) by mouth every morning. An entry in the Physician progress notes, dated 1/24/11, indicated "DON reported that patient is always touching the eyes after touching the anal area. Wanted to start her on some meds to calm her down as per family request." The Behavior Management Book was reviewed on 5/18/11 at 1:00 p.m., there was no sheet for the resident in the book. Interview with the Social Service Director on 5/19/11 at 1:30 p.m., indicated the resident did not have a sheet in the behavior monitoring book due to he had not been notified of recent behaviors. He further indicated if the resident had been having behaviors he was to be notified and a sheet would be initiated and kept in the behavior monitoring book for a year.		Residents who presently exhibit or have exhibited psychological/behavior issues in the last 30 days were reassessed by the SSD/interdisciplinary team to determine if appropriate interventions had been implemented, care planned, and documented in the medical record. **(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** The Social Service Director, Licensed Nurses and Interdisciplinary Care Plan team were re-educated on the facility standards regarding assessment and management of behavior issues and the need for appropriate documentation and follow-up until resolved . The facility employees were reeducated on the facility standards for notification of behaviors to the licensed staff and social services department. The Social Service Director or designee will review new admissions, readmissions, or change of status residents to determine if the residents psychological/behavior concerns have been assessed, care planned and documented according to facility standards The Facility Management Team will review any residents who are displaying any new or escalating psychological/behaviors during the	

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	2. The record for Resident #35 was reviewed on 5/17/11 at 12:10 p.m. The resident's diagnoses included, but were not limited to, depression, schizophrenia, and anxiety. The resident was admitted to the facility on 2/15/11.		Monday through Friday stand up meeting in order to investigate, formulate a plan of care, resolve, or follow-up with any concerns in a timely manner. **(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** The Director of Social Services or designee will review 5 records randomly each week weekly x 4 weeks, then monthly for 2 additional months to determine if the residents psychological/behavior concerns have been properly assessed if needed by Psychological Services, documentation of behaviors is current and with appropriate plan of care. The Facility Risk Manager will report results at the next QA/Risk Management meeting and monthly thereafter until substantial compliance has been achieved and then quarterly monitoring to maintain compliance **(e) Date of compliance:** 6/19/11	

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	Review of Social Service progress notes, dated 2/17/11, indicated the resident had a history of schizophrenia but has not displayed any symptoms in a long time and has been stable. The resident was able to verbalize her needs and denied any symptoms of depression. The last documented Social Service Progress Notes was on 3/11/11 which indicated the resident had a history of falls, and had no signs of depression or behaviors exhibited since her admission. Review of the Psychiatrist Progress Notes, dated 4/25/11, indicated nursing reported she "blows snot" out of her nose and smears feces after putting her hands in her pants. Review of the quarterly Minimum Data			

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	Set (MDS) assessment dated 4/20/11 indicated the resident was able to be understood/understands, there were no behaviors noted, no mood problems, and no delirium noted. Review of the 4/8/11 current plan of care which indicated the behavior problem socially inappropriate as evidenced by contaminates hands and feces and smears stool, spits food and sputum. The nursing approaches were to lay the resident down after meals, report to physician any changes, re-approach resident later, and reinforce positive behavior. Review of the Behavior Monitoring Record indicated symptoms: psychotic symptoms, and hallucinations. Approaches: enjoys country music, talk about her family, 1 to 1 conversation. medications ativan (an antianxiety medication) and thiothixene (an antipsychotic medication). Further review of the Behavior Monitoring Record indicated there were no documented behaviors for this resident were in the book for the months of April or May 2011. Nurse's Notes dated 4/8/11 at 2:15 a.m., indicated resident was awake and sitting on side of bed yelling for toilet paper. The resident had			

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	smeared bowel movement all over bed and clothes. Nurse's Notes, dated 4/8/11 at 9:30 a.m., indicated the resident noted to have smeared bowel movement all over hands, top and pants and wheelchair. Nurse's Notes, dated 4/9/11 at 1:15 p.m., indicated the resident was throwing fecal matter on floor. Nurse's Notes, dated 4/9/11 8:45 p.m., indicated the resident pulled down her pants and removed fecal matter from her private area. Review of the Behavior Monitoring Records indicated none of those behaviors were documented in the book or addressed in the behavior monitoring record. Interview with the Social Service Director on 5/17/11 at 3:00 p.m., indicated that he "dropped the ball" on the resident's behavior of smearing the feces on herself and other items. He indicated that he did not place the feces behavior in the behavior plan or in the book. He further indicated that he did not receive any referral forms from nursing staff regarding the feces smearing. He was also unaware of			

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	the care plan regarding the feces smearing behavior. Interview with LPN #4 on 5/17/11 at 4:00 p.m., indicated the resident has the behavior of being "a digger;" she digs in her feces and smears it on things. The LPN indicated that she has seen her do this on her shift. The LPN indicated she has not filled out a referral form for the behaviors. The LPN indicated the resident still has continued to this behavior about a week ago. Interview with the Director of Nursing on 5/19/11 at 9:30 a.m., indicated her expectations from the nursing staff were to complete a behavior form and give it to social service so the behavior log could be updated. **3. The record for Resident #27 was reviewed on 5/17/11 at 10:25 a.m. The resident's diagnoses include, but were not limited to,** depression, anxiety, and altered mental status. Review of Social Service Progress notes dated 10/10, 11/10, and 12/10 indicated the resident with no behaviors but			

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	yells out "Hey" with periods of disorientation. Review of the significant change MDS assessment dated 3/11 indicated the resident was usually understood and usually understands, has hallucinations, has delusions, physical, verbal, and other behavioral symptoms directed toward others and not directed toward others, intrudes on the privacy or activity of others, and disrupts care or living environment. Review of the current 3/3/11 plan of care indicated behavior problem grabs others yells out swears at people, constant yelling r/t dementia, severe cognitive impairment, family does not allow psychiatrist to see resident.			

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HIGHLAND NURSING AND REHABILITATION CENTER	9630 FIFTH ST HIGHLAND, IN46322

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	The nursing approaches were to report to physician any behavioral changes, explain to resident in advance, reinforce positive behavior, administer medications, re-approach resident later, and intervene as needed. Review of the Behavior Monitoring Record indicated the resident had symptoms of continuous yelling out socially inappropriate, and psychotic symptoms. The first documented behavior in the record was dated 5/6/11 which indicated 12 p.m. and 4 p.m. continuous yelling out 1 to 3 hours, unsuccessful approaches 1 to 1, lay down for a nap and re-approach later. Review of Nurse's Notes dated 5/7/11 8:30 p.m., indicated resident yelling out hey hey as needed (prn) ativan (antianxiety medication) given. Further review of Nurse's Notes dated 5/11/11 indicated the resident was screaming out hey asked if in pain said yes gave pain med given. At 9:15 p.m., resident continues to yell out prn ativan given. Review of Physician orders dated 1/12/11 indicated Lorazepam (an antianxiety medication) 1 milligram (mg). one tablet three times a day (tid) prn for agitation. Review of the 3/11 Medication Administration Record (MAR) indicated the resident received the prn Lorazepam on 3/2 at 3:30 a.m., 3/5/11 at 2:00 a.m., 3/15/11 at 11:30 a.m., and on 3/18/11 at 10:45 p.m. Review of the 4/11 MAR indicated the resident received the Lorazepam on 4/1/11 at 2:00 a.m., 4/16 at 4:00 p.m., 4/20 at 6:00 p.m., 4/23 at 10:30 p.m., and 4/28/11 at 6:30 p.m.			

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	Interview with LPN #2 on 5/17/11 at 12:55 p.m. indicated the resident was not on a behavior monitoring plan currently and has not had any behaviors in the past couple of weeks due to a decline. The LPN indicated when the resident displays a behavior or they have to give her the prn ativan they were supposed to fill out a new or worsening behavior form and place it in Social Service mailbox. Interview with the Social Service Director on 5/17/11 at 3:00 p.m., indicated that he has not received any other referrals from nursing regarding the resident's behavior and receiving the prn ativan. He indicated that he should have received information regarding the resident receiving the prn ativan. The Social Service Director indicated a behavior stays on the care plan for one year regardless if the resident was still displaying it. Further interview indicated the only documented behaviors in the behavior monitoring book was those from 5/6/11 and there had been none prior to that or after that. Interview on 5/17/11 at 3:55 p.m., with LPN #4 who works the 3-11 shift indicated the resident usually yells outloud constantly and all the time. She indicated that she has had to give the resident the prn ativan on several occasions after she had tried 1 to 1 interventions and other interventions before giving her the prn medication. She indicated that she had not completed a referral form when she has had to give the resident the prn ativan and placed it in social service mailbox. Interview with the Director of Nursing on 5/19/11 at 9:30 a.m., indicated her expectations from the nursing staff were to complete a behavior form when the resident			

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	has a behavior so they can communicate that with social service. 4. The record for resident #8 was reviewed on 5/17/11 at 2:10 p.m. The resident had diagnoses that included, but were not limited to, cerebral palsy with mental retardation, and depression. Review of the May 2011 medication administration record indicated the resident was currently receiving Remeron (an antidepressant medication) 30 mg (milligram) daily. The physician progress notes were reviewed. The resident was seen by a psychiatrist on 7/27/10. The progress note dated 7/27/10 indicated, "Psychiatric Consult. Requested to evaluate Pt. (patient) due to her making a "negative" statement. Pt. reportedly made a statement about missing her mother and scored a 4 on the geriatric depression scale, according to the Social Worker, 5 would mean she is depressed. . . Remeron was recently restarted on 7/13/10 for appetite and depression - attending's (physician) note 7/13/10 says Pt. was depressed. Pt. denies feeling depressed at this time. Remeron will be increased to 30 mg at HS (hour of sleep) on tomorrow." The psychiatrist continued to see the			

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	resident monthly. The progress note, dated 2/22/11, written by the psychiatrist indicated, "She is now off Remeron, no problems are reported since the D/C (discontinuation) of the medicine. . . I will sign off at this time." Review of the physician's orders for January 2011 through May 2011 indicated there were physician's order for the resident to receive Remeron 30 mg daily. There was no physician's order to discontinue the Remeron. Review of the medication administration records for January 2011 through May 2011 indicated the resident continued to receive Remeron 30 mg at HS daily. Review of the Social Progress Notes indicated an entry dated 3/20/11. The Social Service Director did not indicate in his progress notes that the psychiatrist was no longer seeing the resident and that the psychiatrist thought the resident was no longer receiving Remeron. Interview with the Social Service Director on 5/18/11 at 3:15 p.m., indicated he was not aware the psychiatrist had written the progress note dated 2/22/11 that indicated the			

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	resident was no longer receiving Remeron and would no longer be seen by the psychiatrist. He also indicated that he knew the resident continued to receive the antidepressant medication. Review of the Behavior Book indicated there was a behavior sheet revised on 4/7/10 that indicated the resident was physically abusive, socially inappropriate and combative with staff, she resists care at times and instigates others. Interview with CNA #2 on 5/19/11 12:25 p.m., indicated she was familiar with the resident and has never seen combative behavior exhibited by her. Interview with Social Service Director on 5/19/11 at 12:45 p.m., indicated the behavior sheet in the Behavior Book was not reflective of the resident's current status. He states he keeps behavior sheets in the book for 1 year, but has left Resident #8's in the book even longer. He states the resident is not combative or physically abusive. He indicated that the resident continues to receive the antidepressant, Remeron, and there is no behavior sheet in the Behavior Book for monitoring the resident's signs and symptoms of depression.			

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	He indicated there should be a sheet in the Behavior Book for signs and symptoms of depression. 3.1-34(a)			
F0253 SS=C	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interviews, the facility failed to ensure the residents' environment was clean and in good repair related to marred door frames, marred walls, discolored caulking around the tile in the bathrooms, and missing baseboard for 2 of 2 hallways, 4 of 4 bathrooms, and for 1 of 1 Dining Rooms. (The front and back hallways, Bathroom #1, #2, #3, #4, and the Main Dining Room) This had the potential to effect 29 residents. Findings include: During the Environmental tour on 5/19/11 at 1:15 p.m., the following was observed: A. The paint was chipped on a 12 inch section around the sink in the Room 5. There were two residents	F0253	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 253- Housekeeping & Maintenance services. (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: a) The area around the sink in Room 5 was sanded and painted. b) Room 7 was patched and painted. c) The door frame in room 8 was sanded and painted. The chair was replaced. d) The closet door in room 9 was painted. e) Room 10 was painted. The cord for the overbed light was replaced. f) Room 11 was painted including the area by the window and the floor box by the wall.	06/19/2011

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	who resided in the Room B. The wall behind the head of the bed for bed "C" was marred and in need of painting and there was a 6 inch gouge in the wall behind the bed in Room 7. There were three residents who resided in the Room. C. In Room 8, the room door frame was scratched and marred. The arms and legs of a straight chair in the room were scratched and marred and was in need of varnish. There were two residents who resided in the room. D. In Room 9, there was a three foot section on the closet door that was marred and scratched. There was one resident who resided in the room. E. In Room 10, the entire wall by bed "B" was marred. There was also no string attached to the over bed light. There was one resident who resided in the room. F. In Room 11, the entire wall was marred and chipped by window near bed including the floor box by the wall. There were two residents who resided in the room. G. In Room 17, there were black		g) The closet door in room 17 was cleaned and painted including the area beneath the doors. h) Room 15 was painted including the above the heater and above the window. The cove base was replaced. i) The cove base in room 18 was repaired. The wall behind bed 2 was patched and painted. j) The tile in bathroom #2 was thoroughly cleaned. A new door is ordered. k) A new door was ordered for the west exit. The corners were cleaned. l) The wall below the chair rail in the Main dining room was cleaned and painted. The trim was installed around the closet door. m) The caulking was replaced around the toilet in bathroom #1. The door frame was repaired and painted. The bathroom was painted and the cove base repaired. n)The wall tile in bathroom #4 was thoroughly cleaned. The kick plate on the door was cleaned. o)The kick plate on the door to bathroom #3 was cleaned. p) The main entrance/exit door was sanded and painted and the frame was repaired and painted. The corners were cleaned. The wallpaper in the back hallway was removed and the wall painted. **(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be**	

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	marks on the bottom of the left closet door and the wall corner near the closet door, this was the bottom one foot of the wall. There were two residents who resided in the room. H. In Room 15, a one inch by five foot section of the wall above the heater was missing paint. A three inch piece of cove base near the closet door was missing. A five foot by three inch area of the wall above the window had no paint. There were two residents who resided in the room. I. In Room 18, the cove base was pulled away from the wall and a one foot section of the lower part of the wall behind bed 2 was cracked and in need of repair. There were two residents who resided in the room. J. Bathroom #2 had discolored caulking around the bathroom floor in the shower area. The caulking was pink and black in color all around the wall tile. The door was splintered door and gouged and had chipped wood. This had the potential to affect 15 residents who were capable of using the four bathrooms in the facility. K. The west exit door was rusted and gauged. The corners were dirty with		**taken:** Residents residing in the facility have the potential to be affected but no specific resident was identified. **(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** Maintenance Director has been inserviced as to the required components of this tag. The standard monitoring and any needed adjustments identified will be during routine environmental rounds and monthly preventative maintenance rounds as the Maintenance Director checks for environmental issues including but not limited to cove base, paint, doors and door frames and Bathrooms tiles. **(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** The monitoring of this tag will be a joint effort between the NHA and the Maintenance Director as they will make weekly walking rounds for the next four weeks and bi-monthly for 2 months as they review the environmental appearance of resident rooms, common areas and bathrooms. A Report of their findings will be discussed at the monthly Risk Management/QA meeting to determine when compliance has been met and quarterly monitoring by the Regional Director of Plant	

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	dirt build up. L. The entire wall below the chair rail in Main Dining Room was marred with black scuffs noted. The trim was missing all around the closet door in the main dining Room. M. The toilet caulking was rusty and was discolored orange/black around the toilet in Bathroom #1. The bathroom door was marred and gauged around the door frame. The walls were marred in the bathroom and a 3 foot section of base board was pulling away from the wall. This had the potential to affect 15 residents who were capable of using the four bathrooms in the facility. N. The wall tile in the Bathroom #4 in the shower room was discolored. A three foot section of grout was discolored black. The kick plate on the door was marred with black marks. This had the potential to affect 15 residents who were capable of using the four bathrooms in the facility. O. The kick plate was marred with black scuffs on Bathroom #3's door. This had the potential to affect 15 residents who were capable of using the four bathrooms in the facility.		Operations/Designee is recommended. **(e) Date of compliance:** 6/19/11	

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	P. The main Entrance/Exit door was marred and there was chipped paint around the door frame. The door frame was also gauged. There was black dirt observed in the corners of the door. The wallpaper in the back hallway by the exit door was marred and scuffed with black marks. **Interview with the Maintenance Director at that time, indicated all of the above was in need of cleaning and/or repair.** **3.1-19(f)**			

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F0278 SS=A	The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on observation, record review and interview, the facility failed to accurately complete the Minimum Data Set (MDS) assessment for 1 of 16 residents whose MDS assessments were reviewed in a sample of 25. (Resident #3) Findings include: Observation on 5/18/11 at 1:18 p.m., indicated the Resident #3 has some	F0278	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 278Comprehensive Assessments (a)What corrective action(s) will be accomplished for those residents found to have been affected by the practice: An oral assessment was completed	06/19/2011

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	missing and broken teeth. The record for Resident #3 was reviewed on 5/18/11 at 1:05 p.m. The resident's annual Minimum Data Set (MDS) assessment, with the assessment reference date of 11/17/10, was reviewed. The Oral/Dental Status portion of the assessment indicated the resident had no broken natural teeth. Interview with LPN #3 on 5/18/11 at 9:40 a.m., indicated the resident has missing and broken teeth. Interview with the MDS Coordinator 5/18/11 at 10:31 a.m., indicated the MDS was inaccurately coded. She indicated the resident's broken teeth should have been coded on the MDS. 3.1-31(d)		for resident #3. A modification of the most recent comprehensive MDS was performed to correct information related to Oral Status. **(b)How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:** All active residents have received an updated oral assessment. The most recent comprehensive MDS assessment for all active residents has been reviewed to ensure that the oral assessment findings are accurately coded on the MDS. Any corrections needed were completed using the modification process per the RAI manual. **(c)What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** The MDS coordinator has been educated on Chapter 3 (section L) of the RAI manual on Oral assessment and MDS coding of Oral Status on the MDS. **(d)How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** DNS or designee will randomly audit at least 5 residents' charts weekly times 4 weeks and then monthly for 2 months to ensure the MDS coding for Oral Status accurately reflects the residents' current oral	

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			assessment findings. The DNS or designee will report their audit findings at the monthly Risk Management\Quality Assurance committee until continued compliance is met, and Quarterly oversight will be completed by the Regional Director of Utilization Review e)Date of compliance: 6/19/11	
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review and interview, the facility failed to ensure a care plan had been developed based on the comprehensive assessment related to range of motion and limitations for 1 of 3 residents reviewed for range of motion of the 7 who met the criteria for range of motion. (Resident #19)	F0279	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 279 – Comprehensive Care Plan (a)What corrective action(s) will be accomplished for those	06/19/2011

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	Findings include: **On 5/17/11 at 10:20 a.m., Resident #19 was observed sitting up in a Broda chair. His left hand was closed in the shape of a fist with a rolled up washcloth noted.** **On 5/17/11 at 2:00 p.m., the resident was in bed. His left hand was closed with a rolled washcloth noted.** **On 5/18/11, at 9:00 a.m. and 11:30 a.m., the resident was sitting in a Broda chair. His left hand was closed and had a rolled washcloth in it.** The record for Resident #19 was reviewed on 5/18/11 at 2:17 p.m. Review of the 2/9/11 Annual Minimum Data Set (MDS) assessment indicated the resident was dependent on staff for Activities of Daily living and had range of motion and limitation impairments on one side of his upper and lower extremities. Review of the Care Area Assessment ADL worksheet indicated "Resident has left sided hemiplegia. He is non-ambulatory needs assist time 1-2 for all ADL's. He makes no attempts to transfer without assist. Vision is lost in left eye but room is set up to accommodate this." Review of the current 5/11 care plan indicated the resident's range of motion and/or limitations to his left hand were not addressed. Review of Occupational Therapy notes dated 8/10 indicated the resident had a contracture to his left hand and elbow and was being		residents found to have been affected by the practice: A care plan for a Restorative Range of Motion program was implemented for resident # 19 as it pertains to contracture management. **(b)How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:** A comprehensive audit of the medical records for all active residents' who have contractures was conducted to ensure that a plan of care addressing the contracture as appropriate is present. **(c)What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** The MDS coordinator was educated per Chapter 4 of the RAI manual as it pertains to the development of the comprehensive plan of care. **(d)How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** DNS or designee will randomly audit at least 5 residents' charts weekly times 4 weeks and then monthly for 2 months to ensure care plans addressing range of motion needs are present as appropriate and representative of the resident's needs and conditions. The DNS or designee will report	

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	splinted and tolerating 4 hours. The functional Maintenance Plan (FMP) was to be implemented and instruct staff and family. Patient was discharged from OT on 8/14/10 due to Patient requires max assist, to leave splints on. Patient refuses to don splints, patient. to be dc' d today 8/14/10. Discontinue splint secondary patient unable to tolerate and has achieved max rehab potential at this time. **Interview with the MDS coordinator on 5/19/11 at 2:30 p.m., indicated the resident's limitations to his left side and his contracture were not care planned.** **3.1-35(a)**		their audit findings at the monthly Risk Management\Quality Assurance committee until continued compliance is met, until continued compliance is met, and Quarterly oversight will be completed by the Regional Director of Utilization Review (e)Date of compliance: 6/19/11	
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to the assessment of skin tears and bruising for 2 of 3 residents reviewed for other skin condition of the 8 who met the criteria for other skin condition. (Residents #32 & #37)	F0309	**Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.** **F 309 Quality of Care Provide Care/Services for highest well being**	06/19/2011

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			(A)What corrective actions will be accomplished for those residents found to have been affected by the practice? Resident # 32 reassessed for bruise on Left hand with documentation of source of bruise with notification to MD and family. No treatment orders obtained area will be monitored weekly on the TAR until resolution. Care plan reviewed and updated for the bruise. Weekly Skin Check was updated to reflect current skin issues. Resident # 37 reassessed for skin tears with review of current treatment orders and proper MD /Family notification. Monitoring of his skin tears will be done daily/weekly on the TAR until resolution. Care plan reviewed and updated. Weekly Skin Check was updated to reflect current skin issues. **(b) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken?** Facility audit was conducted of residents to identify any bruising or skin tears that had not been identified. Any issues identified were addressed and/or corrected. **(c) What measures will be put into place or what systemic changes will be made to ensure that the**	

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			practice does not recur? Direct caregiver staff was reeducated on the facility standard and guidelines for reporting, skin integrity issues on 06/08/11. Licensed nurses will be reeducated on 05/31/11 and 06/07/11 on the facility standard and guidelines for reporting, assessment, documentation and follow-up of resident skin concerns especially skin tears and bruises. The facility management team will review event reports, 24 hour reports, grievances and concerns daily during the Monday through Friday stand up meeting in order to investigate and follow-up on any skin concerns to ensure appropriate documentation and follow-up have been completed. **(d) How will the corrective actions be monitored to ensure the practice will not recur and what quality assurance program will be put into place?** DNS or Designee will audit the 24 hour report 5 times week x 4 weeks and then monthly for 2 additional months for any identified skin issues and will follow up in clinical record to ensure timely MD /Family notification and event reporting. DNS/Designee will audit Weekly Skin Check sheets, TARs, and care plans for identification of skin tears and or bruising for treatment and continued monitoring 3 times weekly x 4 weeks then monthly for 2	

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	1. On 5/17/11 at 10:10 a.m., Resident #37 was observed sitting in a wheelchair. There were clear occlusive dressings noted to areas on the top of the resident's left hand, top of the knuckle area of the right middle finger, and the outer side of the right calf area. The record for Resident #37 was reviewed on 5/17/11 at 2:31 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure, essential hypertension (high blood pressure) and syncope(dizziness). The resident was admitted to the facility on 4/19/11. A Physician's order was written on 5/2/11 to cleanse the skin tear to the		additional months to ensure compliance. Results of these findings will be presented at the monthly Risk Management \Quality Assurance meeting to determine if compliance has been met and quarterly oversight by the RDCO is recommended when she completes her system reviews which includes skin/wound management. . **(e) Date of Correction:** 6/19/11	

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	right middle knuckle with normal saline, apply a dry dressing every 72 hours and as needed until the area healed. The order was changed on 5/2/11 to cleanse the area with normal saline, apply occlusive dressing every 7 days and as needed until healed. A Physician's order was written on 5/7/11 to cleanse the skin tear to the side of the right calf with normal saline, apply occlusive dressing every 7 days and as needed until healed. A Physician's order was written on 5/16/11 to cleanse the skin tear to the top of the left hand with normal saline and apply occlusive dressing every 7 days and as needed. The 5/11 Nurses' Notes were reviewed. An entry in the 5/2/11 Nurses' Notes made at 9:30 p.m., indicated a skin tear to the resident's right hand knuckle area measuring 2.5 cm. (centimeters) x 2.0 cm. with flap noted. The resident stated he bumped it on the side of the doorway. An entry made on 5/3/11 at 11:00 a.m., indicated a new order was obtained for the right middle finger knuckle. An entry made on 5/3/11 at 7:00 p.m., indicated the dressing to the right knuckle was clean, dry, and intact. An entry made on 5/4/11 at			

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	12:00 a.m., indicated the treatment to the right knuckle continues. There were no further ongoing assessment of the skin tear in the 5/11 Nurses' Notes. An entry in the 5/16/11 Nurses' Notes indicated made at 2:00 p.m., indicated a area was observed to the to the left hand measuring 2.7 cm. x 0.1 cm. with a small amount of serosanguineous drainage and no signs of symptoms of infection. The resident informed the writer he bumped the area on a weight in therapy. An entry made in the 5/16/11 Nurses' Notes at 6:00 p.m., indicated the dressing to the left hand was clean, dry, and intact. There were no further ongoing assessments of the skin tear in the 5/11 Nurses' Notes. An entry in the 5/7/11 Nurses' Notes made at 6:15 p.m., indicated the CNA alerted the Nurse to an area on the resident's right calf and a skin tear measuring 2.0 cm. x 1.8 cm. was observed. The resident indicated he bumped it on his walker and staff were to continue to monitor. There was no further documentation of assessments of the right calf skin tear in the Nurses' Notes from 5/8/11 through 5/15/11.			

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A care plan initiated on 4/21/11 indicated the resident had disruption of the skin surface not related to pressure with skin tears noted the lower and upper extremities. Care plan approaches included staff were to complete the Weekly Skin Assessment, monitor for signs and symptoms of infection or delayed healing such as redness and drainage form the areas. Staff were also to provide wound care as ordered and monitor the effectiveness of and response to the ordered treatment.

The 5/11 Weekly Skin Review sheet was reviewed. Entries were made on 5/3/11, 5/10/11, 5/13/11, and 5/14/11. All of the above entries were completed by licensed nursing staff members. The entries all indicated "no new areas of skin impairment" were noted. There was no documentation of the above skin tears or assessments of the above skin tears on the Weekly Skin Review assessment.

When interviewed on 5/18/11 at 2:40 p.m., the Director of Nursing indicated the facility did not have a clear cut policy on ongoing assessment of non decubitus skin areas. The Director of Nursing indicated there should have

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	been ongoing assessments of the areas and the weekly skin sheets did not address an assessment of the areas. 2. Resident #32 was observed on 5/17/11 11:10 a.m. seated in her wheelchair. There was a bruise on her left hand that was 1 inch by 1 inch in size. The record for Resident #32 was reviewed on 5/18/11 at 1:05 p.m. The Nurse's Notes were reviewed. There were entries in the Nurse's Notes dated 5/1/11 through 5/7/11. Review of the entries indicated there was no documentation of a bruise on the resident's left hand. Review of the form titled, "Weekly Skin Review" with dates of 5/6/11, 5/7/11 and 5/13/11 indicated no documentation of the resident's bruise on her left hand. Interview with LPN #3 on 5/17/11 at 1:33 p.m., indicated bruises are to be documented in the Nurse's Notes and followed up for 24 hours or 72 hours. She indicated bruises could be documented on the Weekly Skin Sheet if noted at that time. Interview with the Director of Nursing on 5/18/11 at 2:40 p.m., indicated if a new skin area such as a bruise is noted, staff are to document on the			

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	weekly skin review and are to document in the nursing progress notes. She indicated the documentation should include an assessment of the skin concern which includes the size, the appearance and the location of the skin concern. She also indicated there should be documentation that the physician and the responsible family member were notified of the area. She indicated the skin concern is to then be measured and assessed weekly. An "Event Report" is to be completed with new skin concerns. Continued interview with the Director of Nursing on 5/18/11 at 2:40 p.m., indicated the bruise on Resident #32's hand had not been assessed. She indicated there should be documentation in the Nurse's Notes related to the assessment of the resident's bruise and physician and responsible family notification of the bruise. 3.1-37(a)			
F0311 SS=D	A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.			

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	Based on observation, record review, and interview, the facility failed to provide assistance for oral care for 1 of 1 residents who met the criteria for assistance with Activities of Daily Living. (Resident #21) Findings include: On 5/19/11 at 6:10 a.m., CNA #1 entered Resident #21's room. The CNA indicated she was doing her morning rounds and	F0311	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 311 Maintain ADL's (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Teachable moment was completed with CNA #1 regarding ADL care specifically oral care. Screen sent to Therapy. **(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:** Resident's receiving oral care from CNA #1 had the potential to be affected, no others were identified. **(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** Direct care staff received education on ADL care with specifics on oral care. Therapy to screen and establish oral hygiene protocol for those residents who could benefit from additional education and/or training – with plan to train staff to these and/or any specific recommendations. **(d) How the corrective action(s) will be monitored to ensure the**	06/19/2011

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	was checking the resident for incontinence at this time. The CNA checked the resident for incontinence at this time and provided the resident a urinal to use per the resident's request. The CNA did not provide any other ADL (Activities of Daily Living) care at this time. The next time the CNA entered the resident's room was at 6:55 a.m. The CNA removed the resident's urinal at this time.		**practice will not recur, i.e., what quality assurance program will be put into place:** The DNS will complete walking rounds three times a week with a focus on completion of ADLs specifically oral care. This will be an on-going plan of correction with quarterly oversight by the Regional Director of Rehabilitation and the Regional Director Clinical Operations during Quarterly Systems Review Audit. Report of the outcome of this plan will be reviewed at the next monthly Risk Management/QA Meeting to determine if this has maintain compliance or if additional interventions need to be recommended.e. **Date of compliance:** 6/19/11	

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	The CNA next entered the resident's room at 9:00 a.m. The CNA provided incontinence care and dressed the resident at this time. CNA#1 then assisted the resident into a wheelchair in his room. At 9:42 a.m., the CNA indicated she had finished a.m. care for the resident. The CNA did not provide any oral care or offer to set up the resident's toothbrush or oral care supplies for him throughout this time.			

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	When interviewed on 5/19/11 at 9:55 a.m., CNA #1 indicated she was going to have to shave the resident later as she had not completed that earlier. When interviewed on 5/19/11 at 1:00 p.m., the CNA indicated she had gone back in the resident's room earlier and the resident was given his electric razor and was able to shave on his own. At this time, the CNA indicated she had completed the resident's ADL care.			

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	The record for Resident #21 was reviewed on 5/17/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, anemia, congestive heart failure, and high blood pressure. A care plan initiated on 3/4/11 indicated had a ADL self care deficit. The care plan was last updated on 5/11/11. The care plan indicated the resident needed assistance			

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	with personal hygiene and bathing. Care plan interventions included for staff to provide the amount of assistance or supervision the resident required. The 3/13/11 Minimum Data Set (MDS) admission assessment indicated the BIMS (Brief Interview for Mental Status) score was 14. A score of 13-15 indicated the resident was cognitively intact.			

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	When interviewed on 5/17/11 at 11:00 a.m., CNA #1 indicated she was assigned to care for the resident. The CNA indicated she works the day shift (6:00 a.m. to 2:00 p.m.) and has been assigned to care for the resident many times. CNA #1 indicated the resident was a "day shift get up" meaning the resident was provided a.m. care and gotten up for breakfast on her shift. The CNA indicated a.m. care for the resident is to provide pericare, wash his face and brush his teeth. CNA #1 also indicated the resident needed some assistance with bathing and dressing and can do some			

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	things on his own such as putting on his shirt in the morning. When interviewed on 5/16/11 at 9:11 a.m., Resident #21 indicated staff did not help him as necessary to clean his teeth. The resident indicated he had a toothbrush here and needed the staff to set it up for him to use. When interviewed on 5/19/11 at 1:28 p.m., Resident #21 indicated he had not received assistance to brush			

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	his teeth today. The resident stated staff did not ask him or set him up to do it today. When interviewed on 5/20/11 at 8:20 a.m., the Director of Nursing indicated assistance should have been provided for the resident for oral care and to brush his teeth daily. 3.1-38(a)(2)(A)			
F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interviews, the facility failed to ensure that a resident who was dependent on staff for personal	F0312	Preparation and/or execution of this plan do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth	06/19/2011

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	hygiene received the appropriate services to maintain his Activities of daily living for 1 of 2 residents reviewed for Activities of Daily Living (ADL). (Resident #19) **Findings include:** On 5/17/11 at 10:20 a.m., Resident #19 was observed sitting up in Broda chair. His left hand was closed in the shape of a fist with rolled white washcloth noted. On 5/17/11 at 2:00 p.m., the resident was in bed. His left hand was closed with a rolled washcloth noted. On 5/18/11 at 9:00 a.m., and 11:30 a.m., the resident was sitting up in a Broda chair. His left hand was closed and had a		on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. **F-312 ADL Care for dependent Residents** (a) What corrective action will be accomplished for those residents found to have been affected by this practice: Resident # 19 was provided hand hygiene and nail trimming with placement of clean wash cloth during survey by a licensed nurse with assistance from assigned C NA .A teachable moment for given to the assigned C NA for the presence of dirty wash cloth rolled up in the Resident hand, lack of hand hygiene and dry skin present. (b) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken: A comprehensive inspection of the Residents' finger nails was conducted by nursing to ensure they were clean and trimmed. No other residents were identified to be in need of nail care. **(c) What measures will be put into place or what systemic changes you will**	

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	rolled wash cloth in it. On 5/19/11 at 9:45 a.m., CNA #2 was observed getting the resident out of bed. The CNA was asked to remove the resident's wash cloth in his left hand. The wash cloth was discolored yellow and dirty, and the resident's hand was dry. There was a dried substance in between his fingers. The CNA indicated that she had not washed his hand yet today. Further		**make to ensure that the practice does not recur:** The Nursing staff was re-educated by the DNS/Designee on the facility's standard and guideline for care of fingernails/toenails. Licensed nurses will assess resident nails during the shower//bathing schedule. Toe nails will be cut by the contracted Podiatrist. (d) How will the corrective action(s) be monitored to ensure the practice will not recur, what quality measures will be put into place? DNS and/or Designee will monitor corrective actions to ensure the effectiveness of these actions, including: DNS/Designee will randomly inspect 5 resident's nails weekly x 4 weeks to ensure nail care has been provided per facility's standard and guideline. RDCO will review resident grooming/nail care quarterly during Facility quarterly Systems Review. Findings of the nail inspection audits will be reported at the monthly QA/Risk Management meeting until such time substantial compliance has been met. (e) Date of compliance: 6/19/11	

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	observation indicated the resident's fingernails were very long and jagged. Interview with CNA #2 at that time, indicated the resident was physically not capable of cutting his fingernails. The CNA indicated she has not personally cut his fingernails. She indicated she had thought the residents get their fingernails cut on Sundays The record for Resident #19 was			

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	reviewed on 5/18/11 at 2:25 p.m. Review of the quarterly Minimum Data Set (MDS) assessment, dated 5/9/11, indicated the resident was usually understood and usually understands. The resident was totally dependent on ADL care for bed mobility, transfers, locomotion, eating, personal hygiene, and bathing. Review of the current			

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	plan of care dated 5/9/11 indicated the resident has ADL self care deficit he needs assistance with personal hygiene one assist. The nursing approaches were to provide only the amount of assistance/supervision that was needed, stand by, cueing, contact guarding and weight bearing, explain all procedures and purpose prior to performing task and encourage self performance.			

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	Review of Nursing Progress notes for the month of May 2011 indicated staff must anticipate the resident's needs. There was no documentation the resident refuses nail care in 5/11 Nursing Progress Notes. Interview with the Director of Nursing on 5/19/11 at 11:00 a.m., indicated nail care was to be done as needed (prn) and not necessarily on			

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	Sundays. She indicated Sunday was a good day to do those things because there were no showers on that day. **3.1-38(a)(3)(E)**			
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review and interviews, the facility failed to ensure there was a diagnoses for a resident who had an indwelling Foley catheter for 1 of 3 residents reviewed for Foley catheters of the 6 residents who met the criteria for Foley catheters. (Resident #19) Findings include:	F0315	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 315 Catheters (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: On 5/21/11 physician for resident # 19 was notified that the ESBL was identified as colonized and order received for discontinued of	06/19/2011

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	On 5/17/11 at 2:00 p.m., Resident #19 was observed in bed. At that time, there was a Foley catheter placed in a dignity bag on the side of the bed. 5/18/11 at 9:00 a.m., the resident was sitting up in the Broda chair. At that time, there was a Foley catheter in a dignity bag on the side of the chair. The record for Resident #19 was reviewed on 5/18/11 at 2:17 p.m. The resident's diagnoses		indwelling catheter since there had been no further drainage or penile edema noted. Resident # 19 had a new incontinence screen along with 3-day bladder diary completed without difficulty voiding. Care plan reviewed and revised to reflect out come of the above and current interventions for incontinent d/t DX of CVA w/dementia. Teachable moment given to licensed nurse who failed to obtain diagnosis meeting the criteria for indwelling catheter upon his readmission. **(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:** House-wide audit completed of active residents who have current indwelling catheters to assure that appropriate diagnosis where present and met the suggested criteria for F 315 indwelling catheter placement. Care plans where review and update if needed to assure that the diagnosis was identified. Any issues were corrected upon identification. **(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** In-service education was provided to the licensed nursing staff regarding obtaining an appropriate diagnosis for any residents admitted to the facility with an indwelling catheter or obtaining orders	

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	included, but were not limited to, urinary tract infection, stroke, history of prostate cancer, and urinary retention. Review of Nursing Progress Notes, dated 4/15/11 at 9:00 a.m., indicated the resident was exhibiting penile drainage, the resident's physician was notified and new orders were obtained. Physician orders, dated 4/15/11, indicated a 16 french		for and removing catheters if the resident does not have a diagnosis that requires its presence. New admission charts will be reviewed at the regularly scheduled clinical meeting and orders will be reviewed to ensure that residents who are admitted with indwelling catheters have an appropriate diagnosis and that those residents without a need for the catheter have them removed within 24-hours after admission after obtaining an order by the attending MD. **(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** DNS/Designee will review 24 hour report daily 5 x weekly x 4 weeks then weekly times 2 months to identify any orders and placement of an indwelling catheter. The clinical record will be reviewed including assuring diagnosis meeting the criteria for indwelling catheter placement and care plan revision have been addressed. Report of these findings will be reported at the monthly QA/Risk Management meeting until such time substantial compliance as been met and quarterly oversight by the RDCO is recommended when completing her system review which addresses has a focus on change of condition. **(e) Date of compliance:** 6/19/11	

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	indwelling Foley catheter was ordered. The resident was then admitted to the hospital on 4/20/11 and returned to the facility on 4/27/11 with the Foley catheter. Review of the clinical record indicated there was no assessment or reason for the Foley catheter. Review of the 4/27/11 Physician Order Statement indicated indwelling Foley catheter: Reason UTI and containment ESBL.			

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	Review of the Infection Control Log for the month of 4/11 indicated the resident was readmitted on 4/27/11 from hospital the pathogen was ESBL of the urine and it was colonized on 4/27/11. Interview with LPN #2 on 5/19/11 at 10:00 a.m., indicated she was the nurse who took the order from the physician on 4/15/11 for the Foley catheter. She indicated the			

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	resident was not having any problems urinating at that time, just the penile drainage. Interview with the Director of Nursing on 5/19/11 at 10:30 a.m., indicated there was no diagnoses for the Foley catheter. 3.1-41(a)(2)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure there was adequate indication for use of an as needed (prn) antianxiety medication before it was administered for 1 of 3 residents	F0329	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 329 Unnecessary Drugs (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Issue #1 The active licensed nurses' responsible for Resident # 27 care when PRN ativan given on 3-2-11,3-5-11, 3-15-11, 3-18-11, 4-1-11, 4-16-11, 4-20-11, 4-23-11, and 4-28-11 were re educated to the	06/19/2011

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	reviewed for psychoactive medications of the 5 residents who met the criteria for psychoactive medications. (Resident #27) Findings include: The record for Resident #27 was reviewed on 5/17/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, depression, anxiety, and altered mental status.		importance of attempting and documenting planned interventions and allowing time for effect prior to administering medications to reduce behaviors. Also addressed was the Nurses Notes, Behavior Monitoring Form, documentation reconcile/agree with the interventions attempted and that reflect the effect of each intervention attempted on Nurses Notes and Behavior Monitoring Form. Pharmacy consultant was contacted to review current medications and assure appropriate diagnosis and interventions for each of the psychoactive medications are appropriate for these Residents. SSD was reeducated per teachable moment on the behavior program including the monitoring of residents receiving psychoactive medications and antidepressants. **(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:** A comprehensive review was conducted to identify residents that present with behaviors requiring a specific plan of care, (including step-level-interventions), behavior monitoring sheet, and or/prn medications for behaviors, agitation, insomnia or anxiety. The DNS/Designee reviewed resident clinical records and audited the last 90 days of pharmacy recommendations. Pharmacy recommendations that were found not yet addressed by the physician were forwarded to the physician upon discovery.	

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	Review of Physician orders, dated 1/12/11, indicated Lorazepam (an antianxiety medication) 1 milligram (mg) one tablet three times a day (tid) prn for agitation. Review of the 3/11 Medication Administration Record (MAR) indicated the resident received the prn Lorazepam on 3/2 at 3:30 a.m., 3/5/11 at 2:00 a.m., 3/15/11 at 11:30 a.m., and on		. **(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** Licensed Nurses have been re educated to the standard of investigating possible antecedents (conditions that precipitate/exacerbate 'behaviors) so they may attempt to remove or reduce stressors that could be the source of conflict for the resident. Licensed Nursing staff have been reeducation to the standard of reviewing resident specific plans of care for interventions (skip-level), known to be effective and the importance of assuring nursing notes and BMF ‘s consistently reflect behaviors that occurred , interventions attempted and the results of each intervention attempted prior to administering PRN (as needed) medications. Residents with new or escalating behaviors will be discussed at the AM standup meeting to allow the interdisciplinary team an opportunity to evaluate and revise the current plan of care. The team will perform a review of residents with new or exacerbated behaviors utilizing approved form, “Evaluation of New or Worsening Behavior”. Adjustments to the Plan of care will be made following the completion of the evaluation for the possible psychological, environmental and psychosocial causes of behaviors exhibited. . **(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into**	

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	3/18/11 at 10:45 p.m. Review of the back side of the MAR indicated there was no indication of why the medication was given. Review of Nursing progress notes for the above mentioned dates indicated there was no documentation as to why the medication was given. There was no Behavior intervention Monthly Flow Record for review for the month of March.		**place:** The responsible parties for this plan of correction will include the Director of Social Services and Director of Nursing Services with oversight by the RDCO. Random audits will be conducted on 5 records weekly to assure possible antecedents are investigated (If identified attempts to remove or reduce stressor are made), several resident specific behavior management interventions are attempted and results documented prior to the administration of PRN (as needed) medications. Immediate concerns will be addressed accordingly. Results of the findings will be brought to the next Risk Management/QA meeting to determine if compliance is achieved and quarterly oversight by the RDCO when she completes her system reviews which includes Physician notifications and dosage reductions is recommended. (e) **Date of compliance**: 6-19-11	

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	Review of the 4/11 MAR indicated the resident received the Lorazepam on 4/1/11 at 2:00 a.m., 4/16 at 4:00 p.m., 4/20 at 6:00 p.m., 4/23 at 10:30 p.m., and 4/28/11 at 6:30 p.m. Review of the back side of the MAR indicated there was no indication as to why the prn medication was given. Review of the Behavior intervention Monthly Flow Record indicated the behaviors of			

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	extreme fear and panic were all coded with a "0" meaning the behavior did not occur on the above mentioned dates. Review of Nursing Progress notes for the above mentioned dates indicated there was no documentation indicating why the prn medication was given.: Interview with LPN #2 on 5/17/11 at 1:25 p.m., indicated that when a resident is exhibiting a behavior and has a prn			

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	medication they are supposed to try at least three different approaches including 1 to 1 interventions and if they are unsuccessful then they give the prn medication and document all that information in the chart. Interview with LPN #4 on 5/17/11 at 3:55 p.m., who primarily works the 3-11 shift indicated the resident yells out loud constantly all the time.			

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	She indicated that she has had to give the resident the prn medication on several occasions. **3.1-48(a)(1)**			
F0385 SS=G	A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. Based on observation, record review and interview, the facility failed to ensure the attending physician responded when a resident's change in condition warranted a medical intervention, related to penile swelling and drainage, for 1 of 3 residents reviewed for indwelling Foley catheters of the 6 residents who met the criteria for indwelling catheters. (Resident #19) Findings include:	F0385	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. **F385 - Resident care supervised by a physician** **A) What corrective actions will be accomplished for those residents found to have**	06/19/2011

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	On 5/17/11 at 2:00 p.m., Resident #19 was observed in bed. There was an indwelling Foley catheter drainage bag noted in a dignity bag hanging on the side of the bed. The record for Resident #19 was reviewed on 5/18/11 at 2:17 p.m. The resident's diagnoses included, but were not limited to, urinary tract infection, stroke, history of prostate cancer, and urinary retention. Review of Nursing Progress Notes, dated 4/15/11 at 9:00 a.m., indicated the resident was exhibiting penile drainage, the resident's physician was notified and new orders were obtained. Physician orders, dated 4/15/11, indicated a 16 french indwelling Foley catheter was ordered and to collect a culture of the drainage. Nursing Progress Notes, dated 4/15/11, indicated the Foley catheter was inserted with a clear return of yellow urine. The next documented entries in Nursing Progress Notes were on 4/15/11 at 5:30 p.m., 4/16/11 at 12:00 a.m., 4/16/11 at 9:00 a.m., 4/16/11 at 9:10 a.m., 4/17/11 at 3:20 a.m., 4/17/11 at 9:00 a.m., and 4/17/11 at 6:00 p.m. There was no documentation or assessment of the		**been affected by the practice?** Resident # 19's indwelling catheter has been discontinued as of 5/21/11 with no further drainage or penile edema noted, 3 day bladder diary completed without difficulty voiding. Resident remains incontinent due to Diagnosis of CVA with Dementia. Care plan reviewed and revised. LPN # 2 is no longer employed by the facility. **B) How will the facility identify other residents having the potential to be affected by the same practices?** An audit of the facility's 24 hour report records for the last 7 days with focus on change of conditions that warranted MD notification and a clinical record review was completed. Any identified change of condition not addressed was corrected. **C) What measures will be put into place to ensure the practice does not recur?** Licensed nurses reeducated on the components of this regulation with emphasis on the following: Standard and guideline for Acute Change in Condition with focus of notification to MD timely of any condition warranting a medical intervention and the action to be taken if attending physician non responsive. Licensed nurses were reeducated on	

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	resident's penis or any type of drainage for those entries in Nursing Progress Notes. Nursing Progress Notes, dated 4/18/11 at 4:20 a.m., indicated "...Edema noted to below of penis head. Will continue to monitor." The next entry was on 4/18/11 at 5:55 a.m., which indicated the resident's physician was notified regarding the swelling to the penis, however, the physician stated he did not want to be called this early and to call back at 9:00 a.m. The information was passed on to the day nurse. Nursing Progress Notes, dated 4/18/11 at 10:00 a.m., indicated the Physician called the facility back and stated, "I'll be in today to see him." The next documented entry in Nurse's Notes was on 4/19/11 at 12:00 a.m., which indicated the resident had penile discharge. Nurse's Notes on 4/19/11 at 9:30 a.m., indicated there was swelling and redness noted to the penis without drainage. The Physician was notified of the swelling and redness and stated, "I didn't make it in yesterday. I'm definitely coming in today." Nurse's Notes, dated 4/20/11 at 12:00		the standards and guidelines for Charting and Documentation with focus of acute condition changes. **D) How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?** DNS or Designee will review the 24 hour report daily at the morning clinical meeting 5 times weekly to identify any change of condition warranting a medical intervention. DNS or Designee will review 5 residents' medical records weekly for 4 weeks then monthly for 2 months to ensure that the resident's attending physician has called back or physically assessed a resident within 24 hrs of notification of a change in condition or in such cases if this does not occur that the Medical Director has been notified to ensure the resident's medical care is supervised. Report of the above finding will be discussed at the next Risk Management/QA meeting to determine if compliance has been achieved and quarterly oversight by the RDCO who will complete a system review with focus on change of condition is recommended. **E) Date of correction:** 6/19/11	

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	a.m., indicated there was drainage from the penis and the head of the penis was swollen. Nurse's Notes, dated 4/20/11 at 9:00 a.m., indicated "Copious amounts of yellow brown purulent drainage noted from meatus. Penis is red, swollen and painful to touch. MD (name) aware, stated, 'I swear I'll be there today.'" The next documented entry in Nurse's Notes was on 4/20/11 at 1:50 p.m., which indicated the physician was called again regarding the penile swelling and drainage. The physician stated, "(name) another physician or myself will be in sometime this evening." Nurse's Notes, dated 4/20/11 at 5:30 p.m., indicated the physician was in to see the resident. At 6:15 p.m., the resident's physician gave orders to send the resident to the hospital. At 7:30 p.m., on 4/20/11 the ambulance had arrived to take the resident to the hospital. Review of the Consultation from the hospital, dated 4/21/11, indicated the resident had distal penile edema secondary to parphimosis (is an uncommon condition which the foreskin, once pulled back behind the glans penis, cannot be brought down			

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	to it original position). Interview with LPN #2 on 5/19/11 at 8:30 a.m., indicated the resident was having only penile drainage on 4/15/11 and his penis was not swollen at that time, she indicated she called the doctor and he gave orders to collect a culture of the drainage from the penis. The LPN indicated she was the nurse working on 4/19/11 in the morning and the resident's penis was worse, it was swollen, red, and draining. The LPN indicated at the time she called the doctor and told him and he indicated he would be in that day. Further interview with LPN #2 indicated on 4/20/11 the resident's penis was worse, swollen, red, and draining. She indicated she called the doctor and he stated he would be that day. The LPN further indicated she had made the Director of Nursing aware of both times she had called the physician. The LPN was then asked at what point do you call the medical director and have him look at the resident, she indicated "I want to say I was instructed not to." The LPN indicated the resident's penis had gotten worse since she first saw it with discharge on 4/15/11. Review of the current and undated Notifying the Medical Director of			

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	Issues for Review Policy provided by the Director of Nursing indicated "As much as possible, staff and management will first try to discuss and review the issues or concerns directly with the practitioner. If such a review is not feasible or is unsuccessful, or if residents/patients or families have questions about a practitioner's actions or orders, the staff or management should communicate with the medical director." Interview with Director of Nursing on 5/19/11 at 9:30 a.m., indicated her expectations for the nurses were to call the medical director if the resident's primary physician had not called back or seen the resident within 24 hours. She indicated she was not made aware of the situation until 4/20/11 when she looked at the resident's penis and told the nurse she needed to get a hold of the doctor immediately. **3.1-22(a)(2)**			

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F0406 SS=D	If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. Based on observation, record review, and interview, the facility failed to ensure specialized rehabilitative services were obtained as ordered by the physician related to obtaining an occupational therapy evaluation. This affected 1 of 3 residents reviewed for accidents in the sample of 5 who met the criteria for accidents. (Resident #7) Findings include: Resident #7 was observed on 5/17/11 at 10:10 a.m., seated in a wheelchair in the dining room. Her right leg was in a cast and elevated on the leg rest. The record for Resident #7 was reviewed on 5/18/11 at 3:15 p.m. The resident was admitted to the facility on 1/17/11. The resident has diagnoses the included, but were not limited to, arthritis, diabetes and anemia.	F0406	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 406 Provide/Obtain Specialized Rehab Services (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: New order received to make referral for Occupational Therapy and Physical Therapy to Eval relayed to the FRD. Nursing and staff reeducated on process for notifying therapy of new therapy orders; FRD reeducated to review at morning meeting all new orders, alert to those that are Therapy specific. **(b) How you will identify other residents having potential to be affected by the same practice and**	06/19/2011

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	There was an entry in the Nurse's Notes, dated 5/8/11 at 9:30 p.m., indicating,"Resident returned from OOP (out on pass) with family member (family member's name). Resident had been to (name of hospital) ER (emergency room) d/t (due/to) fall while with family. While in ER resident had X-ray which determined a fracture to right ankle. Ankle is currently wrapped with ACE bandage and is tender to touch. Writer asked resident what happened. Resident stated, "I was going to go to (name of grocery store) when I slipped & fell while trying to go to the car.". . . " The physician was notified of fall with fracture. There was an X-ray report, dated 5/8/11, that indicated, "Fracture of the distal fibula and tibia." There was a physician's order, dated 5/11/11, that indicated "PT/OT (physical therapy and occupational therapy) to eval (evaluate) and treat." Review of the therapy notes indicated no occupational therapy evaluation had been completed. Interview with the Director of Nursing on 5/18/11 at 11:02 a.m., indicated		**what corrective action will be taken:** Physician telephone orders will be reviewed for the past month of April and MTD for May to ensure all therapy orders have been carried out appropriately. **(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** DNS will bring the carbonless copies of orders written to the next morning stand up meeting to review with the interdisciplinary team to ensure that new orders for therapy have been identified. **(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** The correction will be a joint effort between the DNS/MDS/FRD who will review new orders with a focus on therapy orders and their f/u. This will be an on-going plan of correction with quarterly oversight by the Regional Director of Rehabilitation. Report of the outcome of this plan will be reviewed at the next monthly Risk Management/QA Meeting to determine if this has maintain compliance or if additional interventions need to be recommended.	

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	that occupational therapy had missed the physician's order to evaluate the resident. Interview with the Occupational Therapist on 5/19/11 at 10:15 a.m., indicated she was not informed of the physician's order for an occupational therapy evaluation. Interview with the Rehabilitation Manager on 5/19/11 at 10:20 a.m., indicated that referrals to therapy and physician orders for therapy are communicated verbally to her. She stated she was not aware of the physician's order for occupational therapy to evaluate the resident after the fall and fracture. Interview with Director of Nursing on 5/19/11 at 10:50 a.m., indicated she was aware that there was no formal process for nursing to communicate physician's orders for therapy to the therapy staff. She indicated the resident was not evaluated by the occupational therapist as ordered by the physician. 3.1-23(a)(1)		**(e) Date of compliance: 6/19/11**	

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on record review and interview, the facility failed to maintain an Infection Control Program related to the lack of tuberculin testing involving the two-step method at the time of	F0441	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because	06/19/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hire, for 3 of 5 employee records reviewed. (Dietary Employee #1, Housekeeping Employee #2 & CNA Employee #3) Findings include: Employee files were reviewed on 5/20/11 at 9:00 a.m. The following was noted: Dietary Employee #1 was hired on 3/28/11. A tuberculin test was administered on 3/25/11, the results of the testing was not documented. A tuberculin test was administered on 4/24/11, the results were 0 mm (millimeters) a negative result. There was no documentation that a two-step tuberculin test was completed for the employee. Housekeeping Employee #2 was hired on 2/4/11. A tuberculin test was administered on 1/24/11, the results of the testing was not documented. A tuberculin test was administered on 4/22/11, the results of that test were not documented. A tuberculin test was administered on 5/4/11 the results of the test were 0 mm, negative. There was no documentation that a two-step tuberculin test was completed for the employee.		required. F441 Infection Control (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Dietary employee #1, Housekeeping employee #2, and C.N.A. employee #3 had a repeat of their Mantoux series **(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:** No specific residents were found to be affected. **(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** Facility Department Managers was re-educated on new hire process and the importance of each employee completing their Mantoux series. BOM/NHA will monitor new hires to ensure all paperwork is in place and accurate, with a focus of the Mantoux testing and results. **(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be**	

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	155458	A. BUILDING 00 B. WING	05/20/2011

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	CNA Employee #3 was hired on 1/26/11. A tuberculin test was administered on 1/26/11, the results of the testing was 0 mm, negative. A second tuberculin test was not administered. There was no documentation that a two-step tuberculin test was completed for the employee. The policy titled, "Tuberculosis, Employee Screening for" dated August 2007, was provided by the Director of Nursing on 5/20/11 at 11:45 a.m. She indicated the policy was current. The policy indicated: All employees shall be screened for tuberculosis (TB) infection and disease, using a two-step tuberculin skin test (TST) or blood assay for Mycobacterium tuberculosis (BAMT) and symptom screening , prior to beginning employment. The facility's Employee Health Coordinator will administer a TST to all newly hired employees except those who have documented positive TST or BAMT results and those who provide documented verification of having a negative TST or BAMT within the preceding 12 months. Interview with the Administrator on		**put into place:** Monitoring of this will be by the NHA as he performs random audits for the next four (4) weeks on new hire files to ensure completion of employee files which include Mantoux tests If there are no new hires that week he will audit 2 random files weekly for the next 30 days then every two weeks for the next 2 months. Report of all audits will be presented to the Risk management/QA Committee to ensure compliance has been met an quarterly oversight by the RDCO when she completes her system reviews which includes infection control is recommended. **(e) Date of compliance**: 6-19-11	

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	5/20/11 at 10:50 a.m., indicated the 3 newly hired employees had not received the two-step method of tuberculin testing. Interview with the Director of Nursing on 5/20/11 at 11:45 a.m., indicated the facility policy for two-step tuberculin testing had not been followed. 3.1-14(t)(1) 3.1-18(k)			
F0518 SS=C	The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. Based on record review and interviews, the facility failed to follow its emergency preparedness policy related to ensuring there was more than one disaster drill policy book available for facility staff's use. Findings include: Review of the current emergency preparedness policy book updated in	F0518	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 518- Train all staff emergency procedures/drills. (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:	06/19/2011

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	2010 on 5/20/11 at 9:30 a.m., indicated "A copy of this plan shall be maintained in certain areas of the facility, including but not limited to the Administrator office, Nursing station, and Maintenance Department. Employees will be made aware of the location and the contents of the Plan." Interview with LPN #1 on 5/20/11 at 10:10 a.m., indicated she could not find the disaster drill book at the nurse's station, and did not know where it was. Interview view the Maintenance Director 5/20/11 at 10:15 a.m., indicated as far as he knew there was only one book, and he did not have one in his office. Interview with the Administrator on 5/20/11 at 10:25 a.m., indicated there was only one book available in the facility. He indicated he was not aware there needed to be three books, and the book they had was always kept in his office, which was locked when he was not in the facility. **3.1-51(a)**		A copy of the disaster manual was placed at the Nursing Station. The maintenance director has a copy and the DNS has a copy. **(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:** Residents residing in the facility have the potential to be affected but no specific resident was identified. **(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** Maintenance Director has been inserviced as to the required components of this tag. Staff have been inserviced on the location of the disaster drill policy book. The standard monitoring and any needed adjustments identified will be during routine environmental rounds to assure copy is accessible at all times. **(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** The monitoring of this tag will be a joint effort between the NHA and the Maintenance Director as they will make weekly walking rounds for the next four weeks and bi-monthly for 2 months as they review the location of	

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			the books and quiz staff on their knowledge of the location. A Report of their findings will be discussed at the monthly Risk Management/QA meeting to determine when compliance has been met and quarterly monitoring by the Regional Director of Plant Operations/Designee is recommended. **(e) Date of compliance:** 6/19/11	
F9999	STATE RULES 3.1-14 PERSONNEL 1. Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include: documentation of orientation to the facility and the specific job skills. This state rule was not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that all employees received a job specific orientation upon hire for 2 of 5 employee files reviewed. (Employees #1 and #4) Findings include:	F9999	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F-9999 Final Observations - - Alzheimer Training (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Issue #1The identified C N A job specific orientation checklist has been completed and placed within the employee's file. Issue #2 DNS obtained the Alzheimer/Dementia education by RDCO and began in-servicing staff, based on Indiana State Guidelines.Employee #5 LPN, #6 C.N.A. #7 Housekeeper, #8 Housekeeper, #9 Occupational therapy aide, and #10 Physical therapy all received their 3 hour	06/19/2011

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	The facility employee files were reviewed on 5/20/11 at 9:00 a.m. A total of 5 employee files were reviewed. Employee #1 was hired on 3/28/11. There was lack of documentation for orientation to specific job skill as a Dietary Aide. Employee #4 was hired on 3/28/11. There was lack of documentation for orientation to specific job skill as a Certified Nursing Assistant. Interview with the Administrator on 5/20/11 at 10:50 a.m., indicated the employee files were lacking documentation that job specific orientations were completed upon hire. 3.1-14(q)(7) 3.1-14 PERSONNEL 2. In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually		annual training. **(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:** An audit will be conducted of facility personnel to ensure that facility staff have a completed job specific orientation checklist on file. No specific residents were found to be affected. **(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** During new employee orientation the employee will be given a job specific orientation checklist to be completed within the first 30 days after hire and turned into his/her supervisor Department Managers were educated on requirements for job specific orientation · NHA and Nursing Administration were educated on requirements for Alzheimer/Dementia training for staff · Training will be presented upon hire (6 hrs) and annually (3 hrs). · Sign in sheet was revised to include the time, date and location, name and title of instructor, and the program content. The employee will acknowledge attendance by written signature. **(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance**	

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	thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all employees were provided with three (3) hours of dementia-specific training annually, for 6 of 60 employee inservice records reviewed. Findings include: The inservice forms for dementia training completed during the 2010 year were provided on 5/20/11 by the Director of Nursing for review. The individual employee inservice records and the dementia training attendance sheet for the year of 2010 were reviewed. Six of the 60 employees had not received three hours of dementia training during the year of 2010. Employee #5 LPN hired on 5/12/01 Employee #6 CNA hired on 9/4/08		**program will be put into place:** The HFA/designee will conduct monthly audits of personnel files of newly hired employees to ensure that a completed job specific orientation checklist has been completed. The findings of these audits will be brought to the monthly quality assurance/risk management meeting until such time as compliance has been determinedAdministrator will perform random audits for the next four (4) weeks on in-service records and new hire files to ensure completion of required Alzheimer /Dementia training. The results of the random audits will be reviewed at the next RM/QA meeting to determine if substantial compliance has been demonstrated and that it is recommended that monitoring will be quarterly by the RDCO when she completes her system reviews which includes new hire completion. (e) **Date of compliance:** 6-19-11	

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	Employee #7 Housekeeper hired on 6/22/09 Employee #8 Housekeeper hired on 3/14/91 Employee #9 Occupational Therapy Aide hired on 6/12/06 Employee #10 Physical Therapist hired on 2/21/06 Interview with the Corporate Nursing Consultant on 5/20/11 at 11:50 a.m., indicated not all the employees obtained the 3 hours of dementia training in the year 2010. 3.1-14(u)			